Ohio | Department of Medicaid

External Medical Review (EMR) Process Flow for Providers

Provider Journey Maps

February 2023

External Medical Review (EMR) | Overview

Purpose and Considerations

- Purpose
  - » To help providers understand the EMR process for claim and prior authorization denials.
  - » EMR is the review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care entity's (MCE) decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.
- Additional Information
  - » For the purpose of this presentation, MCE covers all MCOs as well as the OhioRISE plan. (MyCare Ohio Plans (MCOP) and the Single Pharmacy Benefit Manager (SPBM) are excluded from EMR).
  - » The cost of EMR is incurred by the MCE.
  - » For the purpose of this journey map, an EMR request can refer to *either* a claim or prior authorization denial review.
  - » For an EMR request to be accepted for review by the EMR entity, the provider must first appeal or dispute the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCE's internal provider appeal or dispute resolution process.

External Medical Review Process

1. After receiving written notification of the internal appeal for a claim or prior authorization dispute, the provider has 30 calendar days to request EMR through the online portal along with submission of required documentation. The provider will indicate in the initial EMR if they are requesting an expedited review.

2. The EMR entity reviews the provider request and determines if the case will receive an EMR.
   a. **If the case is accepted, the** EMR entity provides an acceptance letter to the provider. Go on to Step 3.
   b. **If the case is rejected, t**he EMR entity sends a rejection letter to the provider and to the MCE via the EMR portal.

3. If the provider requested an expedited review, the EMR entity reviews the provider's request and makes the determination if the request to expedite is approved. All EMRs will be reviewed within 30 calendar days unless the expedited review is approved (3 business days).
   a. **If expedited review is accepted,** the EMR entity has three business days to perform review.
   b. **If expedited review is denied,** the case will be downgraded to the standard review timing of 30 calendar days, and the provider will receive a Change of Review Type letter.

External Medical Review Process (cont.)

4. The EMR entity notifies the MCE of the EMR request via the EMR portal and provides all submitted documentation no later than one business day from receipt of the original request. Expedited requests are submitted to the MCE the same day as receipt.

5. Upon receipt of the EMR, the MCE may elect to reverse its decision prior to the EMR review being completed.

a. **If fully reversed within 72 hours,** an EMR Cancellation Letter is provided by the EMR entity to the MCE and provider.
b. **If not fully reversed within 72 hours, the case continues through the EMR process.** Move on to step 6.

External Medical Review Process (cont.)

6. The case is reviewed by the EMR entity. After review, a Determination Letter is provided:

a. **If the EMR entity's decision reverses the MCE's decision in part or in whole**, a determination letter will be sent to the provider and MCE, who must take the following actions in Step 7.
b. **If the EMR entity's decision agrees with the MCE's decision,** a determination letter is sent to the provider and MCE.

7. If the EMR entity reverses the MCE's decision, the MCE must do the following:

a. **For reversed service authorization decisions,** the MCE must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCE receives the decision.
b. **For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member),** the MCE must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.